

**CINCINNATI FIRE DIVISION
MEDICAL RUN REPORT FORM-33**

PATIENT ASSESSMENT											
Eye Opening		Verbal Response		Best Motor Response		Respiration		Skin		Pupils	
4 Spontaneous	5 Oriented	6 Follow Commands	O Normal	O Normal	O Equal						
3 To Voice	4 Confused	5 Localizes Stimulus	O Difficult	O Cyanotic	O Unequal						
2 To Pain	3 Words	4 Withdraws	O Shallow	W ^o M, Hot							
T None	2 Incompr. Sounds	3 Flexion Posturing	<input checked="" type="checkbox"/> Absent	O Palo, Ashen							
	T None	2 Extension Posturing		O Jaundiced							
		1 No Movement		O Diaphoretic							
				O Cool							
BLS RUN			ALS TREATMENT GIVEN			ALS RUN			ALS TREATMENT GIVEN		
Frequency						IV Fluid			Cardiac Treatment		
O Delivery	O MAST Trouser		Type <u>NACL</u>	X Monitor Applied							
Sex M	O Splinting		IV Gauge <u>18</u>	EKG Rhythm <u>Asystole</u>							
Time: _____	O Bleeding Control		By <u>363</u>	Defibrillate <u>200, 300</u>							
Oxygen	Spinal Immobilization			X Suction							
O Cannula	O Cervical Collar			X Intubation <u>843</u>							
O Mask	O Backboard			By <u>843</u>							
O Ambu. Bag	O Head Immobilization										
Dmin. <u>15</u>											
Ambulance/Rescue Unit Assessment upon Arrival. Found Pt is Cardiac Arrest. CPR Initiated by EMT. 1st cardiac monitoring began while by PR, E2 personnel PL in Asystole. 4 BLS + 3 Defibrillation → PEA → PR → V-F. Defib w/ 200J → Asystole → CPR → COT → resit. BLS → 150J → Defib → Defib 300J → Asystole. DMS released → 2nd BLS → Asystole. CPR continued. We noted: very no lidocaine, ET tube → Asystole. Changes in condition CPR / BLS w/ ET three times - typical 1500cc each till also givn. PT → FO staff til reported. Pt → ET tube checked last. Breath sounds R/L but Gurgly type sounds. Dr. D. J. Vermit gave to EMS Arrvt.											
Equipment Left at Hospital											

INSURANCE & EMPLOYER INFORMATION			POLICY HOLDER INFORMATION		
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Other	Relationship to Patient		Sex
Other Name _____			<input type="checkbox"/> Self	<input type="checkbox"/> Parent	<input type="checkbox"/> Male
			<input type="checkbox"/> Spouse	<input type="checkbox"/> Other	<input type="checkbox"/> Female
Policy No. _____			Name _____		
Employer Name _____			Social Security No. _____		
INSURANCE & EMPLOYER INFORMATION			POLICY HOLDER INFORMATION		
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Other	Relationship to Patient		Sex
Other Name _____			<input type="checkbox"/> Self	<input type="checkbox"/> Parent	<input type="checkbox"/> Male
			<input type="checkbox"/> Spouse	<input type="checkbox"/> Other	<input type="checkbox"/> Female

C000134

Exh. 99